IN THE DISTRICT COURT OF THE UNITED STATES
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

CEDRIC LYN JOHNSON (B18840),	)	
	)	
Plaintiff,	)	
	)	
-vs-	)	No. 15 CV 885
	)	
EVARISTO AGUINALDO,	)	
	)	
Defendant.	)	

DEPOSITION OF:

DR. DAVID J. CASPER, O.D.

TAKEN ON: November 17, 2017

Deposition of DR. DAVID J. CASPER, O.D., taken before RUTH E. SHERWOOD, CSR, RPR, and Notary Public, pursuant to the Federal Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, at 15 West Jefferson Street, in the City of Joliet, Will County, Illinois, at 11:12 o'clock a.m. on the 17th day of November, A.D., 2017.

There were present at the taking of this deposition the following counsel:

EXHIBIT C

A P P E A R A N C E S

MR. JOEL KOPPENHOEFER
Cunningham, Meyer & Vedrine
One East Wacker Drive, Suite 2200
Chicago, Illinois 60601

on behalf of the Defendant.

* * * * *

CASPER EXHIBIT: PAGE:

(document marked as requested)

(witness sworn)

DR. DAVID J. CASPER, O.D.,

called as a witness herein, having been first duly sworn, was examined upon oral interrogatories and testified as follows:

EXAMINATION

by MR. KOPPENHOEFER:

MR. KOPPENHOEFER: Sir, can you state your name for the record please.

THE WITNESS: David J. Casper, optometrist.

MR. KOPPENHOEFER: Let the record reflect this is the deposition of David J. Casper, O.D., and set for today's date by subpoena and agreement with the doctor.

By the way, the deposition was set for, noticed for 11:00 o'clock on today's date. It's now 11:12. No one has appeared for the plaintiff, so we're going to go ahead and proceed.

Q Doctor, real quickly, we're here to talk about a patient that you've seen named Cedric Johnson in relation to a lawsuit that he's filed. I'm going to ask you a series of questions about that care. If you have an opinion, feel free to tell me what that is.

Basically I'll be asking for your opinions

to a reasonable degree of certainty within your field. If you don't have such an opinion, you can tell me that as well; otherwise, I'll be asking for your recollections of your care of him and what certain things mean, and we have your records here. Feel free to refresh your recollection by looking at those records, okay?

A Sure.

Q As you can see, we have a court reporter here that's taking everything down, so let's just try to keep a clean record by letting me finish my question before you begin your answer, and I'll do the same before I start my next question.

A Understand.

Q So it appears that you first saw Mr. Johnson on August 25 of 2016.

A Correct.

Q And your note reflecting that visit is marked Exhibit 1.

A Yes.

Q Do you know how it was that Mr. Johnson came to see you on that date?

A He came in for a complete eye examination, and we were in the process of completing the examination and

I requested that he be dilated, and we dilated his eyes after we came up with an eyeglass prescription, and for whatever reason, Mr. Johnson had left the office and I didn't see him again until the next examination in 2017.

Q So he left before the visit was complete?

A Yes.

Q While he was still there, you measured his visual acuity?

A To the best of my recollection, I wrote it down. Frankly, I didn't recall it. I guessed, because again, he was in the middle of something and he was supposed to wait in my reception area, and for whatever reason he chose to leave.

Q And there's a notation of visual acuity of 20/200 in both eyes.

A Uncorrected, that's correct.

Q Uncorrected. Now, and that's sort of your recollection, some sort of after he left and going back in and completing your paperwork?

A No, that was -- that's for sure. The recollection was his best corrected acuity. That 20/200 was established before we even started.

Q And was that established through the visual eye chart?

A Yes, the Snellen acuity chart.
Q And that's the one with the big E at the top, right?
A It's the S L letters that are 20/200.
Q Don't spoil the answers for me. I don't want to be accused of cheating at my next eye exam.
You were able to arrive at an eyeglass prescription for him that would correct that vision?
A Correct. To what degree, I guess 20/25, but frankly I just took that number because I figured he might get there, but I wasn't exactly sure about it, but he walked out and we couldn't get him back.
Q What is it that you would need to do to confirm the examination?
A I would have rechecked him, and also too I would have done a more extensive retinal examination. Basically it's called a dilated fundus examination which I was preparing him for, and I didn't get to do that until his next visit a year later.
Q All right. Now, on August 25 of 2016, he complained of blurred vision far and near with migraines and a blind spot in his left eye since 2014.
A Correct.
Q Now, the blurred vision is something that

basically would be assessed based on what he tells you he sees on the eye chart?

A More than likely, yeah. When you're blurred, you basically use the focal point of your retina to see letters, and if you don't see the letters clearly, you usually complain of blurriness.

Q The migraines of course is simply based on his self report of that to you?

A That's subjective on his part.

Q And then he talked about a blind spot in his left eye. Is that something that -- is that something that people have?

A There is a normal blind spot, but it's not perceived. Based on the testing that I did, gross confrontation and stuff, the best I could determine, I wasn't sure what was going on, and like I say, I didn't really complete the initial examination with him.

When I further examined him the next year, then we found the blind spot, whatever else was bothering him.

Q So were you able to make any objective findings in August of 2016?

A Frankly, I did the best I could with the prescription, and we did an assessment of his retina

without dilation, and it was not a complete exam and we couldn't get him back.

Q Without dilation, were you able to make any assessment of the retina?

A You could see relatively to the back of the eye directly but slightly to the peripheral part. It's more difficult to view unless you're dilated.

The optic nerve that I saw seemed to be okay and whatever else, you know, you could see with the direct ophthalmoscope without dilation, everything seemed to be good, but I at that point dilated him during the exam so I could do more extensive retinal checking, and like I said, that was not able to be done by me.

Q Were you able to ascertain what Mr. Johnson meant by a blind spot in his eye?

A I assume there was someplace that he couldn't see, and we would have gone into it further if we were going to do more extensive health testing, but he walked out after the refraction and we put the drops in his eyes, so we didn't have a chance to discuss anything further and to assess his retina.

Q Now, when Mr. Johnson gave his deposition, he described the blind spot as, quote, white circles that

flash across my eye, end quote.

As an optometrist, if a patient makes a report like that to you, does that indicate anything to you or suggest something to you?

A It suggests perhaps ocular migraines, but a blind spot is basically a spot where you do not see and there's no light. Basically it's dark or gray or you cannot see. Like if I'm looking at you and I perceive a blind spot, this whole area is not going to be visible unless I move my head.

Q There is a phenomenon that people experience with their vision called floaters; true?

A Yes.

Q Can you explain what floaters are?

A A floater is usually in the early years derived from the remnants of a blood vessel that goes from the back of the eye to the lens to nourish the lens during fetal development.

The vitreous is basically compared to like a fresh out-of-the-refrigerator jello at the time that we're born, and most of those fibers disintegrate, get resorbed, or some little particles fall out. If the little particles fall out, they're basically held in place by the vitreous.

The vitreous fibers over years essentially is like a plate of melted jello. If I'm not mistaken, it's like collagen similar to jello proteins, and they get loose and then those particles might come up. If you see those, those are usually just little hair type things or you might suggest or think there's a bug or something like that, little gnat or something, real, real small. Those are essentially not a big deal.

Floaters in general if there are few of them are not really much of a problem. If you see a glob of floaters and they appear all of a sudden and you notice flashes of light, off to the side particularly, that could indicate either a vitreal detachment or a retina detachment.

Q All right. Were you aware that Mr. Johnson was previously assessed with posterior vitreous detachment?

A No.

Q Is that something that you were able to visualize when you looked at his eyes?

A No, and generally those things are relatively benign. Vitreous detachment will probably not affect the vitreous because essentially the vitreous is a sac of tissue which is inside the eye that is adhered to the

retina in a few different places very, very tightly and generally loosely; and over time if you're -- with trauma or aging, sometimes that vitreous will break away from the retina, and if it's a clean break, that's not a problem because it's not going to pull the retina with it. When it pulls the retina with it, that's when you have a vitreous problem and a severe situation you have to deal with.

Q But the posterior vitreous detachment can result in the phenomenon known as floaters; true?

A Oh, yeah.

Q Was there anything else of any substance that came out of that initial visit with Mr. Johnson on August 25 of 2016?

A From a health perspective, I couldn't determine much because I was looking forward to seeing him dilated which I didn't, and had I seen him dilated, I could've assessed it a lot better.

Q By the way, I also noticed in your note that you documented that there was circumcornea hyperpigment in both eyes.

A That's not unusual in darker people.

Q And that's not something that affected his vision, is it?

A That's on the sclera, the white part on the outside part of the eye, and that's due to just basically more pigment than normal, and that usually happens in darker pigmented people.

Q It wouldn't have an adverse effect on his vision?

A No, it's a cosmetic thing that you see on the eyeball.

Q Okay. So you did not see Mr. Johnson again until approximately a year later; is that true?

A Yes.

Q By the way, in that initial visit, did Mr. Johnson relate to you any history about the onset of the symptoms that he was complaining about?

A I don't recall.

MR. KOPPENHOEFER: All right. And then we've got your report and supporting images from the August 16, 2017 visit. I'm going to go ahead and mark those Exhibit 2.

(document marked as requested)

Q So, Doctor, have we marked as Exhibit 2 a true and correct copy of your report from August 16, 2017, with the images you took on that day?

A Yes.

EXHIBIT C

Q Can you tell me, what were the circumstances under which Mr. Johnson came back to see you in August of 2017?

A I was contacted by an attorney representing him and he asked me about my experience with my examination with Mr. Johnson, and I told him based on what I had found so far, the examination was incomplete and I wouldn't be confident in explaining a lot about his condition because I did not do the kind of health evaluation of his eye that I wanted to because we were in the middle of dilation and he left before we completed it, the first visit in August of '16.

Q And as a consequence of that, Mr. Johnson was scheduled to come back in and see you on August 8 of 2017?

A I believe that's the date.

Q And then your report is actually dated August 16.

A That's when I put the report together.

Q Now, can you tell us what you found about his visual acuity on that day?

A Uncorrected he was 20/400, and when we checked him with a pinhole that would kind of give us an idea what he might be able to see, we got a 20/70

correction -- I mean not correction but 20/70 potential with the pinhole in each eye. That was before we did a refraction.

Q Near vision was 20/60?

A Approximately, yes, and we checked that with a Snellen acuity card at 16 inches.

Q And then on this occasion, you were able to arrive at a prescription for corrective lenses for him?

A Yes.

Q By the way, when he arrived, did he come in with corrective lenses?

A I don't recall.

Q What about for the year before when he came in then?

A I don't believe he had glasses then.

Q What was the prescription then for the lenses that you came up with?

A The resulting prescription was for myopia with astigmatism and presbyopia. The prescription that we subjectively came to was minus 75, minus 1, axis 84 in the right eye. In the left eye it was minus 50, minus 1 and a quarter, axis 93 with a one-fifty add for presbyopia.

Q So what was his corrected visual acuity?

A The best corrected in the right eye was 20/40, and in the left eye it was 20/50.

Q Can you sort of tell us, I mean is that -- that's functional vision?

A Central vision of 20/40 without taking into consideration peripheral vision would give a visual acuity to pass a driver's test, but that's not taking into account peripheral vision.

Q Were you able to assess his peripheral vision?

A Once we did some more extensive testing. We have automated visual fields that showed his subjective responses to the visual field test that we provided to him.

Q What was that test?

A The test was a 30-2 Humphrey, and the reason why we did a 30-2 Humphrey is to show the entire peripheral visual field, and you have copies.

Q And this involved asking Mr. Johnson to look at certain things in his peripheral vision area and reporting what he sees?

A No.

Q Explain how it works please.

A The way the test is performed, the individual has a patch on one eye, and the eye that's being tested

is directed to look at one specific point the whole time, and they have to be attentive and they have to be alert to what's going on and they have to essentially fixate on that one point.

As they are fixating on the point, peripheral random points light up, central random, peripheral random, all over the place, and every time the subject perceives light, they should push a button which they're holding in their hand.

Q So it relies on I guess honest participation and reporting by the patient?

A It's frankly subjective. We look at the results, we try to assess them, but the responses that create the result are subjective.

Q All right. And what were the results of that test?

A He measured a very limited central visual field.

Q What does that mean?

A Let me see here from my report I'm picking up. Let me see here.

He basically has a very limited visual field from the visual field test that we performed of -- I believe I noted around five degrees.

Q And that's in the right eye?
A Yeah. The left eye was even worse.
Q What is a typical visual field that you expect to see?
A 70, 80 degrees.
Q So what were the results in the left eye?
A He basically didn't respond. Now, I'm going to clarify the way we usually perform the test. We start with the right eye, and upon completion of the right eye, there's multiple points there that they have to respond to.

Then we do the left eye, and we did the left eye I believe second to the right eye, actually the time stamped at 16 minutes later, and on the left eye he had some areas of vision on the lower quadrants. So particularly I'm looking at the test on the upper right quadrant. He's very, very limited in what he sees of anything from his responses.

And on the left eye inferiorly, he kind of has areas where he's seen a little more than the right eye, but he doesn't have those areas centrally. They're below central on the left eye.

Q Were you able to arrive at an opinion to a reasonable degree of certainty within your field as to

the cause of these visual field results?

A No. I had recommended after getting the result of all my tests that Mr. Johnson have a referral and have a neurological workup.

My perception was is that I see more of a problem behind the eye and beyond the nerve perhaps and including the nerve but not necessarily related to the eyeball and the retina, et cetera.

Q All right. Your examination did not disclose an injury to the eye itself?

A Not internally or externally, no.

Q In the summary section of your report, you noted that Cedric Johnson has an optic nerve defect.

A Yes.

Q Can you tell us what you saw there or what you're able to perceive there?

A The optic nerve defect was perceived as a result of the test. When you see this much darkness in a visual field and you see all the points there and the numbers there, that is very, very limited vision.

And if you look at some of the OCT tests which assess the retina below the outer layers, so you could not see it if you looked at the retina, that's the OCT underneath there, there seems to be some retina

involvement which would be an extension of the optic nerve.

If you look further at the OCT tests, I did an assessment on his optic nerve, and if you look at the results of the OCT test, a professional would see that the involvement of the nerve is minimal that was measured by the OCT.

So I concluded that the extension of the problem or the extent of the problem is beyond the retina and probably more involved beyond the eye.

Q Now, do you have any sense about how this optic nerve defect developed?

A I had no way I could assess his cranium type situation, and from behind his eye, that's where I perceived the problem to be, and I did refer him accordingly and I have yet to get any kind of a report or any kind of knowledge of what happened after he left our office.

Q So in your view, the pathology was within the cranium and that's why you suggested an MRI to look and see what was going on in there?

A Correct.

Q Were you ever provided a history that Mr. Johnson had been shot and had retained shrapnel in

his head?

A I don't recall that; however, I believe I was informed that he had multiple head injuries over the course of his life, and I don't know when it started, but there were multiple times where he had extensive head injury.

Q How did you get that information? Was that from his lawyer?

A I believe so.

Q Okay. So the history, including gunshot wound to the back of the head and being hit in the head with a baseball bat, were you told about that?

A I don't recall, but that would explain his visual field.

Q Pardon?

A That would explain his visual field.

Q So those sort of traumatic injuries to the head could account for the optic nerve defect that you're seeing?

A Specifically the back of the head is where the visual cortex is and everything ends up there, and if you have a cranial injury that's to the back of the head, that is a very likely area to be damaged.

Q At any time in your care of Mr. Johnson, did

he provide you with any specific onset of the symptoms that he was complaining about with his visual field?

A I don't believe so.

Q So just to sort of sum up that, would it be fair to say that the most likely source of injury to the optic nerve would be trauma to the back of the head?

A It would be inside the cranium, and if he had baseball bats to the back of his head and was shot in the back of his head, that's a likely area to pursue as far as doing any further diagnostic testing.

Q If there is an injury to the optic nerve through some sort of trauma, is that something that could be repaired?

A No, and it doesn't necessarily have an injury to the optic nerve as much as it could be the nerve pathway from the back of the eye to the back of the brain.

The optic nerve goes from the back of the eye to the brain and then the brain has all kind of areas where it goes around and then comes to the back of the visual cortex, so a loss of vision could occur anywhere from the back of the eye to the back of the brain.

Q And so once that trauma occurs and resulting

in vision loss or visual field loss, that's just the way that it is?

A To my knowledge, the way medicine is today, there's no way that we could replicate neurological repair of the eye nerves or the nerves in the brain.

Q So that whatever the -- assuming that there was a traumatic insult to Mr. Johnson that caused this situation, there's no doctor that could have intervened to reverse the process, --

A No.

Q -- is that fair?

A If you have extensive nerve damage, you just have to adjust to your circumstances.

Q So I phrased it in a negative, but is what I said true?

A Repeat the question.

Q Let me ask it again without the negative.

Assuming that there was a traumatic insult that led to the visual symptoms that were being described here, there's no doctor that could have intervened to reverse or halt that process, is there?

A Not to my knowledge, not anything in medicine that I know of.

Q Okay. Now, it looks like your office actually

made a neurologist appointment for Mr. Johnson?

A We attempted to. I believe we did. We have yet to get correspondence. And frankly with all this going on, I am going to send him a registered letter asking him to cooperate or go elsewhere.

Q All right. So it would be your anticipation that when a doctor, specifically a neurologist, sees a patient pursuant to your referral, he will write back to you with the results of that referral once completed?

A When I make a referral, I have been doing this since I've been in practice over 30 years, the patient signs their name, gives them the name, address and the phone number where that patient could be contacted.

If we know the referring -- the doctor we're referring to, we will put that name on the form, and on the bottom of the form after the patient releases permission to exchange information, on the bottom of the form I sign it and I request a report of the findings.

Q Okay. And that has not occurred in this case?

A I did not receive anything. Any time this comes to my mind or I'm contacted, I ask the people in the office, did anything come in. My answers are no, and they tried to contact Mr. Johnson and they're not getting any kind of response as to what happened.

Q And so your presumption based on the way the medical practice works, medical recordkeeping is done, is that that appointment has not been kept?

A I honestly don't know. If it was kept, maybe he went somewhere else, maybe he didn't get a report sent to me or requested a report be not sent to me. I -- frankly I can't honestly answer it. All I know is I gave him the referral. We made arrangements to try to get him to go someplace and that was the last contact, and I don't know if he saw anybody or what went on after he left.

Q By the way, your report from August 16 of 2017 indicates at the bottom that the testing that you performed requires attentiveness, understanding and performance on the part of the patient.

A That's specifically related to the visual field; however, when we do a prescription, we do it both objectively and subjectively.

So essentially the visual field is very subjective because if you perceive a light, you push a button and we're assuming that you saw the light. When we're asking you which one is better, which image is better with lens one or lens two, we assume that you're picking the lens that gives you the clearest image.

So we have to base a final prescription usually on subjective findings unless you have somebody who's basically not able to respond, and at that point you do a cycloplegic exam. It's a whole different story.

Q Well, I'm curious. What is a cycloplegic exam?

A In general, I have examined two- and three-year-olds, and I try to get some feedback as to pictures and stuff that they could recognize and see, and sometimes we have people who are severely handicapped mentally and they cannot respond. So what we do is there's a cyclopentolate medicine and that is not usually used to dilate because when you dilate like in Mr. Johnson's case, you want to expand the pupil to get to the back of the eye.

When you use cyclopentolate, the main effect of that drug is to relax the ciliary body focusing muscles of the eye. As that portion of the eye is relaxed, the pupil dilates as a result. That's not your intention, but that shows that your eye is -- the eye that you instill the cyclopentolate in is dilated because the focusing muscle is affected and, therefore, it opens the pupil.

When the ciliary body is relaxed as much as it can be with the medicine, we perform an objective refractive exam. Essentially that examination is a test where we position the patient's head and they have to look at a picture, and generally speaking while they're looking at a picture, we push a button and the machine takes a potential refractive error measurement, and after the eye has been totally relaxed with cyclopentolate, it's pretty easy to get an effective prescription.

Q Does that allow you to check visual field?

A Yeah, you can see the visual field grossly or you could do a subjective test after that, but the purpose of doing that test is to have the total muscle relaxation so you could get an objective measurement that's without influence of focusing.

Q In any event, the test that was performed on Mr. Johnson required subjective reporting from him of the results?

A Yes.

Q Can you tell us whether you were able to make an assessment of his attentiveness, understanding and performance with the test?

A With the refraction, he was relatively

attentive to that. I believe there were some problems with doing the visual fields test where we had to kind of keep him focused on what he was doing there.

Q Can you expound on that? What was he doing?

A I'm reluctant to say this, but the tester said they had to keep telling him to look straight ahead and not sleep.

Q And that was during the visual field portion of the testing?

A Yes. It's about a five- or eight-minute test where you put your chin in a chin rest and you're constantly looking straight ahead. I mean, it's boring for most people.

Q Did Mr. Johnson appear to be when you saw him under the influence of any intoxicant or drugs or anything?

A He was kind of slow to respond, but I didn't conclude it to anything that might be related with that.

Q Okay. And then you talked about the prescription that you made for him. Was he ordered glasses then?

A I believe so.

Q How would that be arranged? I mean, is there a separate supplier that he picks them up from? How

does that work?

A Generally speaking, once your refraction has been complete and we have established a final prescription, we have a dispensary where based on your insurance, the way most of these insurances are today, you have a specific collection of frames you get to choose from and we show you those specific frames that your insurance covers, and most of the insurance companies require us to order all the glasses from the individual's insured laboratory from the insurance company.

Q So in order to know for sure whether glasses were ordered for Mr. Johnson, we would need to check those order forms and your records?

A They're in my records. I didn't think it was necessary for the exam report; otherwise, I would've found out about it.

Q Okay. Real quickly. You are an optometrist; true?

A Yes.

Q And you're licensed by the State of Illinois?

A Yes.

Q Is there board certification for optometry?

A No.

Q Can you tell us briefly where you did your education?

A At the Illinois College of Optometry, and after that, we had to take further courses to be able to use diagnostic drugs, and then in 1996 I went to the Midwestern Medical School and the course was sponsored by the University of Missouri, St. Louis, and we had a six-week course to be re-updated with our pharmaco-logical background and pass various testing to be eligible to prescribe oral and drops and things like that for therapy of glaucoma, et cetera, and also eye infections and things like that.

Q How long have you been practicing as an optometrist?

A Since 1979. I got my license in August.

MR. KOPPENHOEFER: Okay. I don't have any other questions. Thank you, sir.

THE REPORTER: Signature?

MR. KOPPENHOEFER: Do you know about the signature option?

THE WITNESS: No.

MR. KOPPENHOEFER: So she's going to type up the transcript sometime after today. You have the option if you would like of reviewing that transcript for accuracy

and, for example, misspelled words, things that like.

THE WITNESS: I would prefer.

MR. KOPPENHOEFER: So show that signature has been reserved, and we can coordinate how you're going to take a look at it then.

(The deposition concluded at 11:50 a.m.)

EXHIBIT C

IN THE DISTRICT COURT OF THE UNITED STATES
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

CEDRIC LYN JOHNSON (B18840),
Plaintiff,
-vs- No. 15 CV 885
EVARISTO AGUINALDO,
Defendant.

Date of Deposition: November 17, 2017

I hereby certify that I have read the foregoing transcript of my deposition given at the time and place aforesaid, inclusive, and I do again subscribe and make oath that the same is a true, correct and complete transcript of my deposition so given as aforesaid, and includes changes, if any, so made by me.

_____
DR. DAVID J. CASPER, O.D.

SUBSCRIBED AND SWORN TO
before me this _____ day of
_____, A.D., 2017.

_____

George E. Rydman & Assoc., Joliet, IL (815) 727-4363

EXHIBIT C

STATE OF ILLINOIS)
)
COUNTY OF W I L L)

I, RUTH E. SHERWOOD, C.S.R., R.P.R., a Notary Public in and for the County of Will, State of Illinois, do hereby certify that DR. DAVID J. CASPER, O.D. was first duly sworn by me to testify the truth; that the above deposition was recorded stenographically and reduced to typewriting by me; and that the foregoing transcript of the said deposition is a true and correct transcript of the testimony given by the said witness at the time and place previously specified.

I further certify that I'm not counsel for nor in any way related to any of the parties to this suit, nor am I in any way interested in the outcome thereof.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 28th day of November, 2017.

Ruth E. Sherwood

RUTH E. SHERWOOD, C.S.R., R.P.R.
CSR License No. 084-003032

GEORGE E. RYDMAN & ASSOCIATES, LTD.
15 West Jefferson Street
Joliet, IL 60432
(815) 727-4363

November 28, 2017

Dr. David J. Casper
c/o Mr. Joel Koppenhoefer
Cunningham, Meyer & Vedrine
One East Wacker Dr., Suite 2200
Chicago, IL 60601

Re: Johnson vs. Aguinaldo

Dear Dr. Casper:

Please find enclosed herein a copy of your deposition transcript taken on November 17, 2017, which you desired to read and sign.

Please read the transcript carefully and on the enclosed correction sheet, indicating the page number and line number, list any change you feel necessary and the reason for that change.

When you have completed reading the transcript, sign the Signature Page which we have enclosed and have your signature notarized by a Notary Public.

Please return the enclosed Signature Page and the correction sheet to this office within 28 days, as required by Statute. We will then forward any corrections and the Signature Page to all parties concerned.

Your prompt attention in regard to this matter is greatly appreciated.

Yours very truly,

GEORGE E. RYDMAN & ASSOC., LTD.

By: Ruth E. Sherwood
Ruth E. Sherwood, CSR, RPR

cc: file

George E. Rydman & Assoc., Joliet, IL (815) 727-4363

EXHIBIT C